CHILDREN WITH OTHER SPECIAL DIETARY NEEDS

Sponsors of child nutrition programs may, **at their discretion**, make substitutions for individuals who are not "handicapped," as defined in 7 CFR 15b.3 (i), but who are unable to consume a food item because of medical or other special dietary needs. Such substitutions may be made only on a case-by-case basis and when supported by a statement signed by "a recognized medical authority." In such cases, "recognized medical authority" includes physicians, physician assistants and nurse practitioners.

For those nonhandicapped participants, the supporting statement shall include:

- The identification of the medical or other special dietary needs which restricts the child's diet
- The food or foods to be omitted
- The food or choice of foods that may be substituted

In most cases, individuals who are overweight or who have elevated blood cholesterol do not meet the definition of handicapped, and sponsors are not required to make meal substitutions for them. The special dietary need of nonhandicapped participants may be managed within the normal program meal service when a well-planned variety of nutritious foods are available and when Offer Versus Serve is an option.

Contact a School Health and Nutrition Program specialist for additional information (602) 542-8700

MEDICAL STATEMENT
FOR
PARTICIPANTS WITH ALLERGIES/CHRONIC DISEASES

Other medical personnel may complete this for (dietitian, speech pathologist, occupational therapist), but a physician or other recognized medical authority must sign in agreement as to what is written. For purposes of this program, a "recognized medical authority" means a licensed physician, nurse or physician's assistant.

Name of Participant	Age	Agency	
Parent Name	Telephone	Site	Telephone

Food Allergy/Chronic Disease:

_____

_____

_____

Foods To Be Omitted and Substitutions: (Please list specific foods to be omitted and suggest substitutions. You may use the back of this form or attach a sheet with additional information.)

Foods to be Omitted	**Suggested Substitutions**
_____	_____
_____	_____
_____	_____
_____	_____

Signature of Preparer	Printed Name	Telephone	Date
Signature of Recognized Medical Authority	Printed Name	Telephone	Date